COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

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To: Retiree Group Members Eligible for Medicare

From: Charles Reed, Associate Director
State and Local Health Benefits Programs

Date: November 25, 2002

Re: --Your Medicare Plan Monthly Rates Effective January 1, 2003
--Retiree Group Updates

Premium Rates for 2003: Medicare-eligible retiree group members (including retirees, survivors and Virginia Sickness and Disability Program Long Term Disability Participants) will experience premium increases effective January 1, 2003, as detailed below by plan:

Plan**	Current Single Premium	New 2003 Premium
Advantage 65	$209	$236
Advantage 65 + Dental/Vision	$236	$263
Medicare Complementary (Option I)*	$165	$201*
Medicare Supplemental (Option II)*	$250	$274*
Option II + Dental/Vision*	$277	$301*
Dental/Vision Only*	$27	$27*
Drug Only*	$106	$136*
Drug Only + Dental/Vision*	$133	$163*

*These plans are not available to new enrollees. Dental/Vision, Drug Only and Drug Only + Dental/Vision will be discontinued on March 31, 2003--see below for important details regarding these plans.

The enclosed O*pen Forum* newsletter contains more information about your premium increase. Please take a moment to read this material so that you can better understand the reasons for the increased cost of your state health plan.

**All state Medicare-coordinating plans are administered by Anthem Blue Cross and Blue Shield (formerly Trigon). Trigon Blue Cross Blue Shield is now part of Anthem, Inc. On December 2, Trigon's name will change to Anthem Blue Cross and Blue Shield. Questions regarding claim payments should be directed to Anthem Member Services at 1-800-552-2682 (outside of Richmond) or 355-8506 (in Richmond). For additional information, visit the Anthem Web site at www.anthem.com. Once on the site, select "Members & Consumers," then choose "Virginia." On that page, you will find a link to the Commonwealth of Virginia site.

Drug Only and Dental/Vision Plans to be Discontinued: Based on low enrollment and elimination of administrative costs, the **Drug Only Plan**, the **Drug Only + Dental/Vision Plan** and the **Dental/Vision Plan** (as a stand-alone option) will be discontinued on March 31, 2003. Current participants may remain in these plans until March 31, 2003, or they may cancel coverage before that date per plan provisions. This will have no effect on participants who have added Dental/Vision coverage to their Advantage 65 or Option II plans.

The Department of Human Resource Management recognizes the critical need for continuous group health plan coverage for its retiree group members. In an effort to ensure access to continued coverage, current participants in the Drug Only, Drug Only + Dental/Vision and Dental/Vision Plans will have a one-time option to enroll in Advantage 65 or Advantage 65 + Dental/Vision. To exercise this option, the enclosed Enrollment/Waiver Form must be received at the location designated on the first page of the form no later than March 31, 2003 (or enrollment may be completed by using Employee Direct on the Web at http://edirect.state.va.us). **Otherwise, if no action is taken by March 31, 2003, current enrollees and their covered dependents (regardless of the plan in which the dependents are enrolled) will be canceled effective March 31, 2003.** Those participants who exercise the option to enroll in Advantage 65 or Advantage 65 + Dental/Vision will have their plan changed effective the first of the month after receipt of their enrollment form (or enrollment through Employee Direct).

Please consult the enclosed *Medicare Options Brochure* for an overview of Advantage 65 plan benefits. Participants who take this one-time opportunity to enroll in Advantage 65 (or Advantage 65 + Dental/Vision) will receive a new membership card as described under the "New ID Cards" section of this memorandum. However, enrollment forms received between January 1 and March 31, 2003, will generate a new ID card in approximately four weeks.

No Copayment/Coinsurance Level Changes: All copayment and coinsurance benefit levels will remain unchanged for 2003.

Change in Medicare Supplemental (Option II) Prescription Drug Claims Filing Procedure: Participants enrolled in Medicare Supplemental (Option II) will experience some improvements to their Major Medical benefit for prescription drugs. New identification cards will be issued and should be presented at the time of a prescription purchase. **More information is included in a flyer that is enclosed for all current Option II members.** Be sure to read the flyer carefully to ensure that you are getting your best possible prescription drug benefit. **Failure to present your new Option II identification card at the time of a prescription purchase could result in higher drug expense to both you and the program.**

How to Make Plan Changes: If you wish to maintain your current plan and membership level, do nothing. Your new monthly premium will automatically be deducted or billed in the usual manner. If you wish to make an allowable change in your retiree group health plan coverage per plan provisions, your completed enrollment/waiver form must be received no later than December 31, 2002, for a January 1, 2003, effective date. (You may also make changes using Employee Direct on the Web by December 31, 2002.) Additional enrollment information regarding the one-time option for Dental/Vision and Drug Only participants to elect Advantage 65 are detailed previously in this memorandum.

Vision Benefits: Effective January 1, 2003, participants enrolled in Medicare Complementary (Option I), Advantage 65 + Dental/Vision or Option II + Dental/Vision will receive an increased vision benefit as follows:

Vision Benefits	***The Plan Pays:***
Routine Vision Exam (once every 24 months)	*Provider's charge up to a maximum of $40 per routine exam (unchanged)*
Frames (one pair every 24 months)	*Provider's charge up to a maximum of $75 per pair (formerly $50)*
Lenses (one pair of eyeglass lenses or any type of contact lenses every 24 months) • *Single lenses* • *Bifocal lenses* • *Trifocal lenses* • *Contact lenses (hard, soft, or disposable)*	*Provider's charge up to the maximum amounts specified below for the types of lenses provided:* *$50 per pair (formerly $35)* *$75 per pair (formerly $50)* *$100 per pair (formerly $70)* *$100 (unchanged)*

These benefits will also apply to current Dental/Vision and Drug Only + Dental/Vision participants who maintain coverage until March 31, 2003, and are eligible for vision benefits.

Medicare Managed Care Plan Waiver No Longer Available: The option to waive state coverage to enroll in a Medicare Managed Care Plan will no longer be available after December 31, 2002. After that date, any participant who terminates coverage to participate in a Medicare Managed Care Plan will not have an opportunity to return to the state program.

New ID Cards: All participants will receive new identification cards by January 1, 2003, even if no plan or membership change is made. The new cards will reflect the Anthem Blue Cross and Blue Shield logo. Changes made by submitting an enrollment form will generate an updated card. Enrollment forms received after mid-December will generate another updated card which should be received by mid-January. So, while allowable enrollment changes will be accepted until December 31, the earlier your enrollment form is received, the faster your updated identification card will be generated. Participants may also make changes by using Employee Direct on the Web at http://edirect.state.va.us.

Be sure to discard your old card and begin using your new card on January 1, 2003, or as soon as it is received after January 1.

Member Handbook Amendments: Along with your new identification cards, you will receive an amendment to your current Member Handbook. Be sure to place this amendment with your handbook as an update. New handbooks will not be printed at this time.

Medicare Eligible Participants: When an enrollee (retiree, survivor, VSDP/LTD participant) or their covered dependent becomes eligible for Medicare prior to age 65, an Enrollment/Waiver Form must be submitted immediately to indicate a Medicare-coordinating plan selection. It is the responsibility of the enrollee to ensure adherence to this provision. **Failure to do so could result in significant coverage deficits.**

This is an important provision of the State Retiree Health Benefits Program. All participants who are eligible for Medicare must also enroll in both Parts A and B in order to get the full benefit of any state Medicare supplemental coverage since Medicare becomes the primary payer of

claims. If it is determined that a participant is eligible for Medicare and has not enrolled in a Medicare-coordinating plan, he or she will be placed in a Medicare-coordinating plan immediately, and primary claim payments made in error may be retracted. If participants have declined their Medicare Part B coverage, it could also result in a delay in Part B enrollment and, as a result, a critical gap in coverage until Part B coverage goes into effect.

Direct Billing of Premiums: For some retirees, an increased premium will mean that the amount of your monthly retirement annuity will no longer be sufficient to cover your monthly premium amount. In those cases, you will begin to be billed directly by Anthem. Keep in mind that, due to administrative differences, direct billing occurs in advance of the coverage month, while annuity-deducted premiums are collected in arrears.

Prompt Payment of Premiums: Plan participants are responsible for paying their premiums (either through annuity deduction or by direct payment to the carrier) in the time frame required. Participants who pay directly to the carrier receive monthly bills which specifically indicate when premium payments are due. Monthly premiums that remain unpaid for 31 days after the due date will result in termination of coverage.

Participants are responsible for understanding their premium obligation and notifying the program within 31 days of any qualifying mid-year event that affects membership level. Premiums which are incorrect due to failure of the participant to advise the program of membership reductions may result in loss of premium overpayments. Failure of the participant to remove ineligible dependents may result in retraction of claim payments and suspension from the program.

Retiree Meetings: In early December, there will be a series of meetings held around Virginia to discuss the State Retiree Health Benefits Program and to answer questions regarding plan provisions. A schedule is included in the enclosed *"Open Forum."* The retiree meetings held last fall were well received and, while budget constraints have limited the number of meeting locations, we look forward to more constructive dialogue with retiree group members in December.

Health Insurance Portability and Accountability Act Privacy Notice: Please be sure to review the enclosed **Employee/Retiree Privacy Notice** that explains how medical information about you may be used and disclosed and how you can get access to this information based on the requirements of the Health Insurance Portability and Accountability Act of 1996.

Newsletter: Please take a moment to read the enclosed *Open Forum* newsletter, which contains information about health plan issues related to retiree group members.

Enclosures:

- State Health Benefits Program Enrollment/Waiver Form
- Medicare Plan Options Brochure
- *Open Forum* Newsletter
- Medicare Supplemental (Option II) Drug Claim Flyer (enclosed for current Option II members only)
- Health Insurance Portability and Accountability Act Privacy Notice